NAMI Connecticut

National Alliance on Mental Illness

Testimony of the National Alliance on Mental Illness (NAMI) Connecticut
Before the Judiciary Committee
March 18, 2016

IN OPPOSITION TO
Raised H.B. No. 5531 AN ACT CONCERNING THE CARE AND TREATMENT OF PERSONS WITH A MENTAL ILLNESS OR SUBSTANCE USE DISORDER

Senator Coleman, Representative Tong and members of the Judiciary Committee, my name is Daniela Giordano and I am the Public Policy Director with the National Alliance on Mental Illness (NAMI) Connecticut. NAMI Connecticut is the state affiliate of NAMI, the nation's largest grassroots mental health organization dedicated to building better lives for all those affected by mental health conditions. NAMI Connecticut offers support groups, educational programs, and advocacy for quality of life for individuals and families in the community. I am here today on behalf of NAMI Connecticut to oppose Raised *HB 5531 An Act Concerning the Care and Treatment of Persons with a Mental Illness or Substance Use Disorder.*

This bill proposes to give Probate Courts the authority to appoint a conservator, prior to discharge from a health care facility, for a person in the community who has been diagnosed with a mental illness or a substance use disorder. This conservator would have the authority to consent to the administration of medications over the person's objections, despite the person being capable of giving consent and simply exercising his/her protected right to decline treatment, including medications.

We oppose this bill, and proposals along these lines, for a *myriad of reason* (including damaging the therapeutic relationship between individuals and health care providers, driving individuals away from treatment and adding more racial disparities in mental health treatment), many of which you will hear or already have heard about from people testifying today. I want to focus on just a few. Mental health is part of and integral to overall health and wellbeing and thus should not be treated any differently than other health conditions. Despite this, there are no other illnesses for which we would presume that we should use legal force to make someone take medications. In fact, it has been documented that over fifty percent of people who are prescribed heart medications do not take them or take them erratically,[1] but no one would *even think* we should use the 'intervention' of a court order, health care 'police' and actual law enforcement, to make people do so, especially when individuals live in the community. The same issues apply to people who have diabetes and many other chronic health conditions.

[1] Steven Baroletti, PharmD, MBA; Heather Dell'Orfano, PharmD. Medication Adherence in Cardiovascular Disease. Retrieved on 3/16/16 from http://circ.ahajournals.org/content/121/12/1455.full.pdf+html

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Also, using the concept of people being 'treatment resistant' or 'non-compliant' is a faulty one. It requires an individual to fit into or conform to a treatment system, including when that 'system' is not fully coordinated, and most likely lacks the capacity, and sometimes skills, to do effective outreach and engagement with individuals to take care of their health concerns. Instead, 'the system' is the player that needs to find ways to engage individuals in person-centered and individualized ways, and not give up on people. Additionally, the system most likely lacks the full range of services, supports and housing that individuals would find helpful, at the time they would be helpful, and thus is not able to effectively connect people with this much broader range of services. This is an especially grave concern in our current budget climate, which threatens to deeply cut current mental health and substance use services and supports, which are not adequate as is. Forcing individuals to undergo forced treatment is unconscionable, even in a good service climate, but even more so in these difficult times.

Involuntary outpatient commitment (or as it is euphemistically often called 'assisted outpatient treatment') has not been proven to work. Research has not been able to conclusively determine whether positive outcomes are the result of court orders, or access to and improved treatment by itself. Research on outpatient commitment conducted in New York found no statistically significant differences in re-hospitalization rates, arrests, or other outcomes between participants who received involuntary outpatient care and those receiving intensive outpatient care without a court order.[2] The Cochrane Collaborative review of outpatient commitment studies concluded in 2012 that "Compulsory community treatment results in no significant difference in service use, social functioning, or quality of life compared with standard care."[3] Dr. Tom Burns, Social Psychiatry Chair at the University of Oxford and an early proponent of IOC, reassessed that support after a study he conducted found that mandated outpatient treatment did not make any difference in hospital readmissions, length of stay or severity of symptoms. He stated that, "I had hoped that adding compulsion would move the proportion who do well up, but the evidence is stubbornly consistent that it doesn't."[4]

On the other, very positive side, Connecticut is a leader (and has been for many years) in recovery-oriented services that focus on an individual's self-determined process and goals for their lives and wellbeing and has produced positive results *without* coercion and the violation of individuals' rights – individuals who are members of a class protected by our state's Constitution. *Empowering and proven effective practices* include the following – each of which would be a better investment instead of dropping scarce resources into a costly and unproven coercive hole:

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[2] Steadman, H. J., Gounis, K., Dennis, D., Hopper, K., Roche, B., Swartz, M., & Robins, P. C. (2001). Assessing the New York City involuntary outpatient commitment program. Psychiatric Services, 52(3). Retrieved from http://ps.psychiatryonline.org/article.aspx?articleid=85619

[3] Kisley, S.R., Campbell, L.A., & Preston, N.J., (2011, February 16, online publication). Compulsory community and involuntary outpatient treatment for people with severe mental disorders. The Cochrane Collaboration 2012. Editorial Group: Cochrane Schizophrenia Group. DOI: 10.1002/14651858.CD004408.pub3. retrieved online 10/6/14. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004408.pub3/abstract

[4] Patt Morrison, "Column: Can Laura's Law help the mentally ill? Researcher Tom Burns' surprising conclusion." Los Angeles Times, July 22, 2014. http://www.latimes.com/opinion/op-ed/la-oe-morrison-burns-20140723-column.html#page=1(accessed 10/8/14); Burns, T. (2013). Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial, The Lancet, 381: 9878: 1627 – 1633.]

- ✓ **Peer support interventions**, in which persons with lived experience engage persons whose needs are not being met by the current service system. One such effective program is Peer Bridger, Anatar miTana, which means 'for the relationship to continue, it is important for them to bridge their differences';
- ✓ **Expanded outreach and support** for persons with intensive needs, including through assertive community treatment (ACT) teams
- ✓ **Supportive housing**, a proven, cost-effective approach to promoting stability and self-sufficiency by offering affordable housing combined with self-selected supportive services;
- ✓ **Citizenship initiatives** to support recovery by engaging individuals in activities that enhance their sense of belonging through valued roles in their communities, including as practiced and offered through the Yale Program for Recovery and Community Health (PRCH);
- ✓ **Specialized young adult services** to provide age appropriate interventions and supports as offered by programs around the state;
- ✓ **Wellness programs** that support individual health through nutrition, mindfulness training, yoga and other positive activities as provided by Advocacy Unlimited's intentional living space Toivo and other initiatives;
- ✓ **Jail diversion, crisis intervention team (CIT) trainings, alternatives to incarceration, re-entry programs and conditional releases** to prevent inappropriate use of the correctional system; and
- ✓ **Advance Directives**, which give individuals more control over their health care decisions when they are unable to make or communicate their decisions, by creating a proactive document that spells out an individual's preferences, including what interventions work and don't work for someone.

Connecticut, through both the legislative process as well as workgroup and taskforce processes, has rightfully rejected involuntary outpatient commitment *numerous times* over the past twenty years. It is time to do so again – and continue to support individuals to have access to proven, effective and cost-effective solutions!

Thank you for your time and attention. Please let me know if I can answer any questions for you.

Respectfully, Daniela Giordano